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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Philipp Leo Bannwart, M.D.** **BAHNHOFPLATZ 6** **3920 ZERMATT 99** **Switzerland** **Physician's and Surgeon's Certificate No. A 83871,** Respondent.	Case No. 800-2017-035909 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about July 2, 2003, the Medical Board issued Physician's and Surgeon's Certificate Number A 83871 to Philipp Leo Bannwart, M.D. (Respondent). The Physician's and

Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on February 28, 2019, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

". . ."

5. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

6. Section 2234 of the Code, states, in relevant part:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

" . . . "

7. Section 2242(a) of the Code states that prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022[1] without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

BACKGROUND FACTS

8. At all times relevant to this matter, Respondent was licensed and practicing medicine in California.

9. Respondent treated, on an outpatient basis, Patient P-1[2] from July 21, 2011 to February 1, 2012[3]. Patient P-1 was a 49 year old female, with a past medical history of poly-substance abuse, post-traumatic stress disorder, bipolar disorder, chronic pain syndrome and a history of overdose. Respondent prescribed multiple opioid medications to Patient P-1 including methadone[4], hydrocodone[5] and codeine[6]. Over the course of five months, Respondent increased Patient P-1's methadone from 60 milligrams per day to 200 milligrams per day, which has a morphine milligram equivalent of 2400.[7]

10. On July 21, 2011, Patient P-1 was treated by Respondent at Concord Health Center for chronic pain partially related to a fall from May 29, 2011 where she had been admitted at John

[1] Dangerous drug means any drug unsafe for self-use in humans or animals including drugs that require a prescription to be lawfully dispensed.

[2] The patient is designated in this document as Patient P-1 to protect her privacy. Respondent knows the name of the patient and can confirm her identity through discovery.

[3] The only medical records available are from this time period, however, Respondent may have treated her longer than indicated in the medical records per his statements during the investigation.

[4] Methadone is a synthetic narcotic analgesic with multiple actions quantitatively similar to those of morphine. It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance. Methadone exhibits a non-linear relationship due to the long half-life and accumulates with chronic dosing.

[5] Hydrocodone is an opioid/narcotic pain reliever used to treat moderate to severe pain. It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance.

[6] Codeine is an opioid analgesic used to treat mild to moderately severe pain. It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance.

[7] Morphine milligram equivalency (also known as MME) is used to convert the many different opioids into one standard value based on morphine and its potency. Oxycodone, for example, is 1.5 times as potent as morphine so 100 milligrams of oxycodone is equivalent to 150 MME.

Muir Medical Center. Patient P-1 stated her pain was a 7 out of 10 and was generalized. Respondent prescribed 180 pills of 10 milligrams of methadone to Patient P-1.

11. On August 10, 2011, Patient P-1 was treated again by Respondent for pain management issues. Respondent noted in the chart that Patient P-1 was almost blind and he referred her to Ophthalmology. Patient P-1 was prescribed 320 10 milligram pills of methadone between Respondent (300 pills) and another physician (20 pills). The total methadone dosage per day was 100 milligrams.

12. Respondent treated Patient P-1 again on September 1, 2011 for a follow-up visit and Patient P-1 stated her pain was 9 out of 10 and was "uncontrolled" but that pain levels improved on higher doses of methadone. She had run out of pain medication the day before and was "withdrawing." On September 12, 2011, Patient P-1 called the Concord Health Center stating the pharmacy would not fill her prescription because the dosage was increased. Patient P-1 returned for follow-up on September 14, 2011 for medication as there was some difficulty getting her methadone approved by insurance.

13. On October 5, 2011, Patient P-1 was treated by Respondent for a follow-up to get methadone refilled and said it worked well with her pain.

14. In October and November 2011, Respondent prescribed 480 pills totaling 160 milligrams of methadone per day. In addition, Respondent prescribed 180 10 milligram hydrocodone/acetaminophen pills totaling 60 milligrams per days (an MME of 60 per day). Respondent also prescribed 480 milliliters of 10 milligram/5 milliliters codeine promethazine syrup[8] with an MME of 4.8 per day.

15. On December 19, 2011, Patient P-1 was seen by Respondent for follow-up and medication refill after having been hospitalized as suicidal because of uncontrolled pain. She stated her pain was 9 out of 10 and the methadone dosage was "not enough". Respondent referred Patient P-1 to John Muir Behavioral Health Center but she started experiencing shortness

[8] Promethazine-codeine syrup is a prescription medicine used to temporarily treat cough and upper respiratory symptoms. It is a Schedule V controlled substance, and, if taken in conjunction with benzodiazepines, or other central nervous depressants, including alcohol, can cause severe drowsiness, breathing problems (respiratory depression), coma and death.

of breath and was denied admission without a medical clearance by Respondent. Respondent spoke with Patient P-1 on January 4, 2012 regarding her cough and to discuss her breathing troubles/bronchitis/wheezing. On January 5, 2012, Respondent medically cleared Patient P-1 to be treated at John Muir.

16. On January 11, 2012, Patient P-1 called Respondent because the pharmacy requested Patient P-1 ask him for a new prescription for Norco.[9] On January 11, 2012, Dr. N.F. called Respondent to advise that Patient P-1 fell out of her wheelchair on January 10, 2012 and was walking down the street "totally out of it" and wanted to know whether to stop Depakote[10] because Patient P-1 claimed that Depakote caused the problem. The medical records are unclear as to whether Respondent contacted Dr. N.F. to follow-up. On January 15, 2012, Respondent prescribed 180 pills of 10-mg hydrocodone/325 milligram acetaminophen with an MME of 60 per day. On January 16, 2012, Respondent prescribed 600 pills of methadone for 200 milligrams per day with an MME of 2400 per day.

17. Patient P-1 was admitted to John Muir hospital from January 24, 2012 to January 28, 2012 for respiratory failure secondary to narcotic and benzodiazepine overdose and was in an altered mental status secondary to drug overdose. She was found unresponsive by her son and taken by ambulance to the hospital. Patient P-1 had previously been admitted to John Muir hospital for opioid overdose on "multiple occasions". Patient P-1 had difficulty with her sight but had several large bottles of medication with her in different strengths which was noted to not be a "safe situation" and she was to be followed by a Home Health RN for medication review. Respondent was cc'd on the medical records related to this hospitalization.

18. Patient P-1 was discharged from the hospital on January 28, 2012 and on January 31, 2012, a home health nurse called Respondent to alert him that Patient P-1 was "taking

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[9] Norco is a trade name for hydrocodone bitartrate with APAP (hydrocodone with acetaminophen) tablets. Norco 325/10 reflects that each pill contains 325 mg of acetaminophen and 10 mg of hydrocodone bitartrate. Hydrocodone bitartrate is a semisynthetic narcotic analgesic and a dangerous drug as defined in section 4022 and a Schedule III controlled substance.

[10] Depakote is the brand name for Valproic Acid and is an anticonvulsant used to treat seizures and bipolar disorder.

medications that she should not be taking" and wanted to discuss possibly getting her a social worker. Respondent called back and left a message per medical records.

19. Concord Health Center prescription records show the following prescriptions written by Respondent: on February 7, 2011: Methadone: 10 mg with 120 quantity; on April 11, 2011: Methadone: 10 mg and Oxycodone with Acetaminophen (Percocet)[11] 5 mg/325 mg: 90 tabs quantity (one week supply at a time); on April 20, 2011: 180 tabs of methadone 10 mg; on July 21, 2011: 180 tabs of 10 mg methadone and 90 tabs of 5 mg/325 mg Percocet; on August 10, 2011: 240 tabs of 10 mg methadone and 180 tabs of 10 mg/325 mg Norco; on September 1, 2011: 180 tabs of 10 mg/325 mg Norco; on October 5, 2011 480 tabs of 10 mg methadone and 180 tabs 10 mg/325 mg Norco; On October 31, 2011 480 tabs of 10 mg refilled by Dr. A.K.; December 19, 2011: 600 tabs 10 mg Methadone, 240 ml 6.25 mg/10 mg promethazine-codeine syrup and 180 tabs of Norco 10 mg/325 mg; in December 28, 2011 240 6.25 mg/10 mg promethazine-codeine syrup; on December 29, 2011: 240 ml 6.25 mg/10 mg promethazine-codeine syrup; January 11, 2012: 600 tabs of 10 mg methadone; 180 tabs Norco 10 mg/325 mg; 240 ml promethazine-codeine syrup 6.25 mg/10 mg; January 25, 2012: 240 ml promethazine-codeine syrup 6.25 mg/10 mg. On January 19, 2012 and January 25, 2012, Respondent ordered 240 milliliters of Promethazine-Codeine syrup (6.25 mg/10 mg) for Patient P-1. On January 25, 2012, Respondent prescribed 180 tablets of Norco (10/325 mg) with one refill remaining.

20. Repondent was interviewed on October 11, 2018 regarding his treatment of Patient P-1. Respondent recalled Patient P-1 ran out of methadone in November 2011 and compensated with alcohol and became suicidal and had to be hospitalized. He described her as a "very, very challenging patient." Respondent admitted considering tapering his patient, however, he did not do so. Respondent also admitted he did not have access to CURES but that he had called the pharmacy to access CURES. Respondent was questioned about the CURES prescription report which showed that he prescribed methadone amounts of 10 milligram, 600 pills in December

[11] Percocet is a trade name for Oxycodone and Acetaminophen combined. Oxycodone is an opioid pain medication sometimes called a narcotic and Acetaminophen is a less potent pain reliever that increases the effect of the oxycodone. Oxycodone is a dangerous drug as defined in section 4022 and a Schedule II controlled substance. It is a more potent pain reliever than morphine or hydrocodone.

2011 and 10 milligram, 600 pills in January 2012 and stated "that does not sound right." These prescription levels were later confirmed from a CVS Pharmacy patient prescription profile that showed that on December 19, 2011, Respondent wrote a prescription for methadone (10 milligrams, 600 tabs) and again on January 16, 2012 (10 milligrams, 600 tabs).

21. Patient P-1 died on February 5, 2012 and the coroner listed her cause of death as "acute methadone intoxication."

CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence/Repeated Negligent Acts/Incompetence/Improper Prescribing Without an Appropriate Prior Examination and Medical Indication)

(Code Sections 2234(b), (c), and (d); 2242)

22. Respondent is subject to disciplinary action under section 2234, subdivisions (b) (gross negligence), (c) (repeated negligent acts), (d) (incompetence) and 2242 (improper prescribing) in that Respondent has committed gross negligence and/or repeated negligent acts and/or incompetence in the practice of medicine as described above, including, but not limited to, the following:

A. Respondent failed to reduce the dosage of opioids prescribed by reassessing the need for opioids every three months and determining if the dosage should be tapered. Respondent stated that he considered tapering Patient P-1 from methadone but instead he increased the dosage and even added additional opiate medication over a period of five months and Patient P-1 subsequently died of methadone intoxication.

B. Respondent failed to refer Patient P-1 to an addiction or pain specialist despite dosages of greater than 80 morphine milligram equivalents per day. Patient P-1 received 2400 morphine milligram equivalents per day without referral to an addiction or pain specialist.

C. Respondent failed to take steps to account for, and was unaware of, the amount of narcotics prescribed to Patient P-1. For example, Respondent did not review the state prescription drug monitoring program (CURES) despite Patient P-1 being prescribed opioids. Respondent admitted that he had no access to CURES, however, he called the pharmacy and

requested that the pharmacy access CURES, yet Respondent did not appear to understand the amount of medications that Patient P-1 was being prescribed.

D. Respondent prescribed Patient P-1 more than one central nervous system depressant in combination. Patient P-1 was treated by multiple clinicians who prescribed a combination of benzodiazepines and opioids and Respondent apparently did not check CURES or take other steps to determine what prescriptions Patient P-1 obtained from other prescribers and failed to limit or taper the combinations of central nervous system depressants.

E. Respondent failed to use drug testing before starting opioid therapy for chronic pain, and failed to take other steps to verify the patient's compliance with a treatment plan. For example, Respondent did not consider regular urine drug testing at least annually to assess the combinations being used including other prescribed medications, as well as other controlled prescription drugs and illicit drugs.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 83871, issued to Philipp Leo Bannwart, M.D.;

2. Revoking, suspending or denying approval of Philipp Leo Bannwart, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Philipp Leo Bannwart, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: December 17, 2018

KIMBERLY KIRCHMEYER
Executive Director
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State of California
Complainant

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